1988

THE MEDICARE HANDBOOK

A comprehensive guide to your medicare hospital and medical insurance benefits

1988

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CONTENTS

USING YOUR MEDICARE HANDBOOK

This section tells you about:

Your Medicare Handbook is designed to help you determine if the services you need are covered by Medicare and how program payments are made. It is intended to be a handy reference to help you understand how the Medicare program works and to know what your benefits are. There is an alphabetical index at the back to assist you in finding information on specific subjects. While Medicare pays for many of your health care expenses, **it does not cover all of them.** Therefore, it is important for you to know in advance what Medicare does and does not pay for.

Handbook Highlights

- Page 20 provides a list of the services and supplies that Medicare cannot pay for.
- Page 22 tells you how to submit your medical insurance claims.
- Beginning on page 28, there is an address list showing you where to send your medical insurance claims.
- Page 18 tells you how to appeal if you disagree with a Medicare decision or the amount of payment on a claim.

If you have questions not answered by this handbook or would like additional information, you may call your nearest Social Security office or one of the private insurance organizations listed on pages 28 to 32 of this handbook.

People eligible for Medicare because of kidney disease should ask for a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*.

WHAT IS MEDICARE?

The Medicare program is a Federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

The two parts of Medicare

There are two parts to the Medicare program. **Hospital Insurance** helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care. **Medical Insurance** helps pay for medically necessary doctors' services, outpatient hospital services, home health care, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

Both parts of Medicare have deductible and coinsurance amounts that you must pay out-of-pocket or through coverage by another insurance plan. Hospital insurance deductible and coinsurance amounts usually increase on an annual basis each January 1 according to formulas established by Congress. When this occurs, you will be notified.

Intermediaries and carriers

The Federal government contracts with private insurance organizations called **intermediaries** and **carriers** to make Medicare payments. **Intermediaries** make coverage and payment decisions on services in hospitals, skilled nursing facilities, home health agencies and hospices. **Carriers** handle claims for services by doctors and other suppliers covered under Medicare's medical insurance program.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the Federal government to review the hospital care of Medicare patients. Each State has a PRO to

help Medicare decide whether care is reasonable and necessary, is provided in the appropriate setting, and meets the standards of quality accepted by the medical profession. Where such standards are not met, PROs have the authority to deny payments. In addition, PROs respond to requests for review of hospital decisions or reconsideration of PRO decisions. They also investigate individual patient complaints. If you are admitted to a Medicare participating hospital you will receive *An Important Message From Medicare* which explains your rights as a hospital patient and provides the name, address, and phone number of the PRO for your State.

If you feel that you are improperly refused admission to a hospital or that you are forced to leave the hospital too soon, ask for a written explanation of the decision. **Medicare regulations require that such a written notice must fully explain how you can appeal the decision** and it must give you the name, address, and phone number of the Peer Review Organization where your appeal or your request for review can be submitted. (See page 18 for a more complete discussion of your appeal rights under Medicare.)

Who can provide services and supplies

Providers of services and supplies under Medicare must meet all licensing requirements of State or local health authorities. They must also meet additional Medicare requirements before payments can be made for their services. Medicare providers must also comply with Title VI of the Civil Rights Act which prohibits discrimination because of race, color, or national origin. The provider or your Social Security office can tell you if the provider is Medicare certified.

Medicare cannot pay for care you receive from a hospital, skilled nursing facility, home health agency, or hospice that is not certified to participate in the program. Such providers are referred to as non-participating. But hospital insurance can help pay for care in a qualified non-participating hospital if (1) you are admitted to the non-participating hospital for emergency treatment and (2) the non-participating hospital is the closest one that is equipped to handle the emergency. Medicare defines emergency treatment as treatment that is immediately necessary to prevent death or serious impairment to health.

If the non-participating hospital elects to submit the claim for Medicare payment, Medicare will pay the hospital directly except for any deductible or coinsurance amounts. If the hospital does not submit the claim, you may submit the claim and receive payment. Any Social Security office can help you file the claim. In this case, you would reimburse the hospital.

PRIVATE HEALTH PLAN OPTIONS

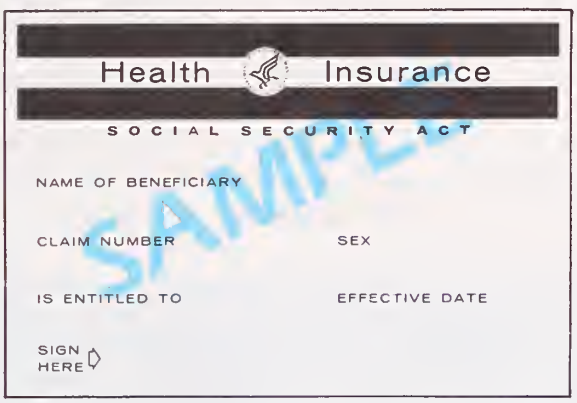
Many prepayment plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs) have contracts with Medicare. These plans receive direct payments from Medicare for services covered by both hospital insurance and medical insurance. Many HMOs and CMPs may also offer you additional services beyond what Medicare covers.

If you are thinking about choosing an HMO or CMP, there are some requirements and restrictions that you must consider. (1) You must be enrolled in Medicare's medical insurance. (2) You must live within the geographic area which is served by the HMO or CMP under Medicare contract. (3) You may be required to pay a fixed premium as well as any copayment or deductibles for some of the other services provided by the plan in addition to paying Medicare's medical insurance premium. (4) If you have elected hospice care, you are ineligible to enroll in an HMO or CMP as long as the hospice election remains in effect. (5) If you have end-stage renal disease, you are not allowed to enroll in an HMO or CMP. However, if you are a member of an HMO or CMP and develop end-stage renal disease, you may not be disenrolled. (6) You may be required to receive all care from the HMO or CMP, except in emergency situations.

You will retain your regular Medicare appeal rights after enrolling in an HMO or CMP and will also have access to the prepayment plan's grievance procedures. You will also have the option of being able to disenroll from an HMO or CMP and still retain Medicare hospital insurance and medical insurance eligibility. Disenrollment can be handled by your plan or your local Social Security office. If you want to know whether there are prepayment plans having contracts with Medicare in your area, contact a Social Security office.

YOUR MEDICARE CARD

The Medicare card (see below) shows the Medicare coverage you have (hospital insurance, medical insurance, or both) and the date your protection started. If you don't have both parts of Medicare, see page 21 for information on how you may obtain the part you don't have.



Your card also shows your health insurance claim number. Sometimes, this claim number is referred to as your Medicare number. The claim number has nine digits and a letter. On some cards, there may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, each will receive a separate card and claim number. Each spouse must use the exact name and claim number shown on his or her card.

It is important that you remember to:

(1) Always show your Medicare card when you receive services that Medicare can help pay for.

(2) Always write your health insurance claim number (including the letter) on any bills you send in and on any correspondence about Medicare. Also, you should have your Medicare card available when you make a telephone inquiry.
(3) Carry your card with you whenever you are away from home. If you ever lose it, immediately ask your Social Security office to get you a new one.
(4) Use your Medicare card only after the effective date shown on it.
(5) Never permit someone else to use your Medicare card.

BUYING SUPPLEMENTAL HEALTH INSURANCE

Medicare provides basic protection against the high cost of health care, but it will not pay all of your medical expenses nor most long-term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare or cover long-term care. The Federal Government does not sell or service such insurance.

If you are thinking about buying private insurance to supplement your Medicare protection or cover long-term care, please shop carefully. Contact your State Insurance Commissioner's office for information. It is in your telephone directory under State Government listings.

If you want help in deciding whether to buy private supplementary insurance, call any Social Security Office and ask for the pamphlet, *Guide to Health Insurance for People with Medicare*. This free pamphlet, which is published by the Health Care Financing Administration, describes the various kinds of supplemental insurance policies available and explains how they relate to Medicare coverage.

FRAUD AND ABUSE HOT LINE

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services or is billing Medicare for services you did not receive, a toll-free Hot Line has been installed by the Department of Health and Human Services' Inspector General so that you may report any evidence of such fraud, waste, or abuse of the Medicare program.

The toll-free number is (800) 368-5779. In Maryland, call (800) 638-3986. Or you may send your complaints in writing to:

HHS, OIG, Hot Line
P.O. Box 17303
Baltimore, Maryland 21203-7303

Please do not call the Hot Line for Medicare policy questions or questions about delayed claims or payments.

HOSPITAL INSURANCE

This section tells you about:

THE PROSPECTIVE PAYMENT SYSTEM

In 1983, Medicare began using a new system of paying most hospitals (except hospitals in Maryland and New Jersey), called the Prospective Payment System. Under the Prospective Payment System hospitals now are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high, or the length of stay is unusually long, the hospital receives additional payment.

It is important to remember that this new system does **not** change your Medicare hospital insurance protection as described in this handbook. It does not determine the length of your stay in the hospital or the extent of care you receive. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than applicable deductible and coinsurance amounts, plus any amounts due for noncovered items or services, such as television, private duty nurses, or cosmetic surgery.

MEDICARE HOSPITAL INSURANCE

Medicare hospital insurance helps pay for four kinds of care: (1) inpatient hospital care; (2) medically necessary inpatient care in a skilled nursing facility after a hospital stay; (3) home health care; and (4) hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare can help pay for in each benefit period. But, your hospital insurance protection is renewed every time you start a new benefit period.

Skilled nursing facility care is the only type of nursing home care that Medicare covers. Medicare does not pay for care that is primarily custodial.

Benefit periods

A benefit period is a way of measuring your use of services under Medicare hospital insurance. Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 11).

Here are two examples of how the benefit period works:

Example 1: Mrs. Jones enters the hospital on January 5th. She is discharged on January 15th. She has used 10 days of her first benefit period. Mrs. Jones is not hospitalized again until July 20th. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period and her hospital insurance coverage is completely renewed.

Example 2: Mrs. Smith enters the hospital on August 14th. She is discharged on August 24th. She also has used 10 days of her first benefit period. However, she is then readmitted to the hospital on September 20th. Since less than 60 days elapsed between hospital stays, Mrs. Smith is still in her first benefit period and the first day of her second admission is counted as the 11th day of that benefit period. Mrs. Smith will not begin a new benefit period until she has been out of the hospital (or skilled nursing facility) for 60 consecutive days.

Medicare hospital insurance will pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that hospital insurance can pay for.

You do not have to send Medicare any bills for care you receive from a participating hospital, skilled nursing facility, home health agency or hospice. Medicare will pay its share of the costs directly to the place where you received the care.

Whenever a hospital, skilled nursing facility, or home health agency sends Medicare a hospital insurance claim for payment, you will get a *Medicare Benefit Notice* that explains the decision made on the claim and shows what services Medicare paid for. If you have any questions about the notice, get in touch with the office shown on the notice.

WHEN YOU ARE A HOSPITAL INPATIENT

Medicare hospital insurance can help pay for inpatient hospital care if **all** of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

Hospital insurance can help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period.

During 1988, from the 1st day through the 60th day in a hospital during each benefit period, hospital insurance pays for all covered services except the **first** $540. This is called the hospital insurance deductible. **The hospital may charge you the deductible only for your first admission in each benefit period.** If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again.

From the 61st through the 90th day in a hospital during each benefit period, hospital insurance pays for all covered services **except for $135 day**. The hospital may charge you for the $135 a day.

Page 7 explains how hospital reserve days can help with your expenses if you ever need more than 90 days of inpatient hospital care in a benefit period.

Hospital insurance does **not** cover your doctor's services even though you receive them in a hospital. Doctors' services are covered under Medicare medical insurance. Page 11 tells how medical insurance helps with doctor bills.

Major services covered when you are a hospital inpatient

Medicare hospital insurance **can** pay for these services.

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care unit, coronary care unit, etc.
- Drugs furnished by the hospital during your stay
- Blood transfusions furnished by the hospital during your stay (see page 7 for information about coverage of blood)
- Lab tests included in your hospital bill
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- Medical supplies such as casts, surgical dressings, and splints
- Use of appliances, such as a wheelchair
- Operating and recovery room costs, including hospital costs for anesthesia services
- Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient

Medicare hospital insurance **cannot** pay for these services

- Personal convenience items that you request such as a television in your room
- Private duty nurses
- Any extra charges for a private room unless it is determined to be medically necessary

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

Hospital inpatient reserve days

We said earlier that Medicare will help pay for your care in a hospital for up to 90 days in each benefit period. But what happens if you have a long illness and have to stay in the hospital for more than 90 days? Medicare hospital insurance includes an extra 60 hospital days you can use if this ever happens. These extra days are called reserve days. During 1988, hospital isurance pays for all covered services **except for $270 a day** for each reserve day you use. You are responsible for this $270. **Once you use a reserve day you never get it back**. Reserve days are **not** renewable like your 90 hospital days in each benefit period.

Since you have only 60 reserve days in your lifetime, you can decide yourself when you want to use them. After you have been in the hospital 90 days, you can use all 60 reserve days at one time if you have to stay in the hospital that long. But you don't have to use your reserve days right away if you don't want to. Maybe you have private insurance that can help pay your hospital bill if an illness keeps you in the hospital for more than 90 days. If you don't want to use your reserve days, you must tell the hospital in writing ahead of time. Otherwise, the extra days you need to be in the hospital will automatically be taken from your reserve days.

Coverage of blood under hospital insurance

Hospital insurance can help pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance can pay all of these blood costs, **except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells in each benefit period**. The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or a blood assurance plan replace it for you. A hospital or skilled nursing facility **cannot** charge you for any of the first 3 pints of blood you replace or arrange to replace. (See page 17 for explanation of coverage of blood under Medicare medical insurance.)

Care in a psychiatric hospital

Hospital insurance can help pay for no more than 190 days of care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, hospital insurance cannot pay for any more care in a psychiatric hospital, even if you have some or all of your reserve days left.

Also, there is a special rule that applies if you are in a participating psychiatric hospital at the time your hospital insurance starts. Any Social Security office can give you information about this special rule.

Care in a foreign hospital

Medicare generally **cannot** pay for hospital or medical services outside of the U.S.

(Puerto Rico, The Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States, along with the 50 States and the District of Columbia.) However, it can help pay for care in qualified Canadian or Mexican hospitals in three situations. These are: (1) you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital which can provide the emergency services you need, (2) you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists, and (3) you are in Canada traveling by the most direct route to or from Alaska and another State and an emergency occurs which requires that you be admitted to a Canadian hospital.

When hospital insurance covers your inpatient stay in a Canadian or Mexican hospital, your medical insurance can cover necessary doctors' services and any required use of an ambulance. If the hospital does not submit the claim to Medicare, any Social Security office will help you get Medicare payment for the covered services you receive. If you are planning to travel overseas, you may want to inquire about the availability of special short-term health insurance for foreign travel.

Care in a Christian Science sanitorium

Medicare hospital insurance can help pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanitorium if it is operated, or listed and certified by, the First Church of Christ, Scientist, in Boston.

SKILLED NURSING FACILITY CARE

After you have been in a hospital, Medicare hospital insurance can help pay for inpatient care in a participating skilled nursing facility if your condition still requires daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services. Most nursing homes in the United States are **not** skilled nursing facilities and many skilled nursing facilities are not certified by Medicare. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility or a particular portion is certified to participate in Medicare as a skilled nursing facility, ask someone at the facility or call a Social Security office.

Hospital insurance can help pay for care in a skilled nursing facility if **all** of the following five conditions are met:

(1) you have been in a hospital at least 3 days in a row (not counting the day of discharge) before your transfer to a participating skilled nursing facility,
(2) you are transferred to the skilled nursing facility because you require care for a condition which was treated in the hospital,
(3) you are admitted to the facility within a short time (generally within 30 days) after you leave the hospital,
(4) a doctor certifies that you need, and actually receive, skilled nursing or skilled rehabilitation services on a daily basis, and,
(5) the Medicare intermediary or the facility's Utilization Review Committee does not disapprove your stay.

All five conditions must be met. But it's especially important to remember the requirement that you must need skilled nursing care or skilled rehabilitation services on a daily basis.

Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

The skilled nursing care and skilled rehabilitation services you receive must be based on a doctor's orders.

Hospital insurance **cannot** pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once

or twice a week, or if you do not need to be in a skilled nursing facility to get skilled services. Also, hospital insurance **cannot** pay for your stay if you are in a skilled nursing facility mainly because you need custodial care (see page 19).

When your stay in a skilled nursing facility is covered by Medicare, hospital insurance can help pay for up to 100 days in each benefit period, but **only** if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 30 days, you do not have to have a new 3-day stay in the hospital in order for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehablilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, your care can be covered.

In each benefit period, hospital insurance pays for all covered services for the first 20 days you are in a skilled nursing facility. During 1988, for the 21st through the 100th day, hospital insurance pays for all covered services except for $67.50 a day. You may be charged this amount by the skilled nursing facility.

Hospital insurance does not cover your doctor's services while you are in a skilled nursing facility. Medicare medical insurance covers doctor's services. Page 11 tells you how medical insurance helps with doctor bills.

Major services covered when you are in a skilled nursing facility

Medicare hospital insurance can pay for these services.

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Rehabilitation services, such as physical, occupational, and speech therapy
- Drugs furnished by the facility during your stay
- Blood transfusions furnished to you during your stay (see page 7 for information about coverage of blood)
- Medical supplies such as splints and casts
- Use of appliances such as a wheelchair

Some services not covered when you are in a skilled nursing facility

Medicare hospital insurance **cannot** pay for these services.

- Personal convenience items that you request such as a television in your room
- Private duty nurses
- Any extra charges for a private room, unless it is determined to be medically necessary
- Custodial nursing home care services provided to persons with chronic, long-term illnesses or disabilities.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

HOME HEALTH CARE

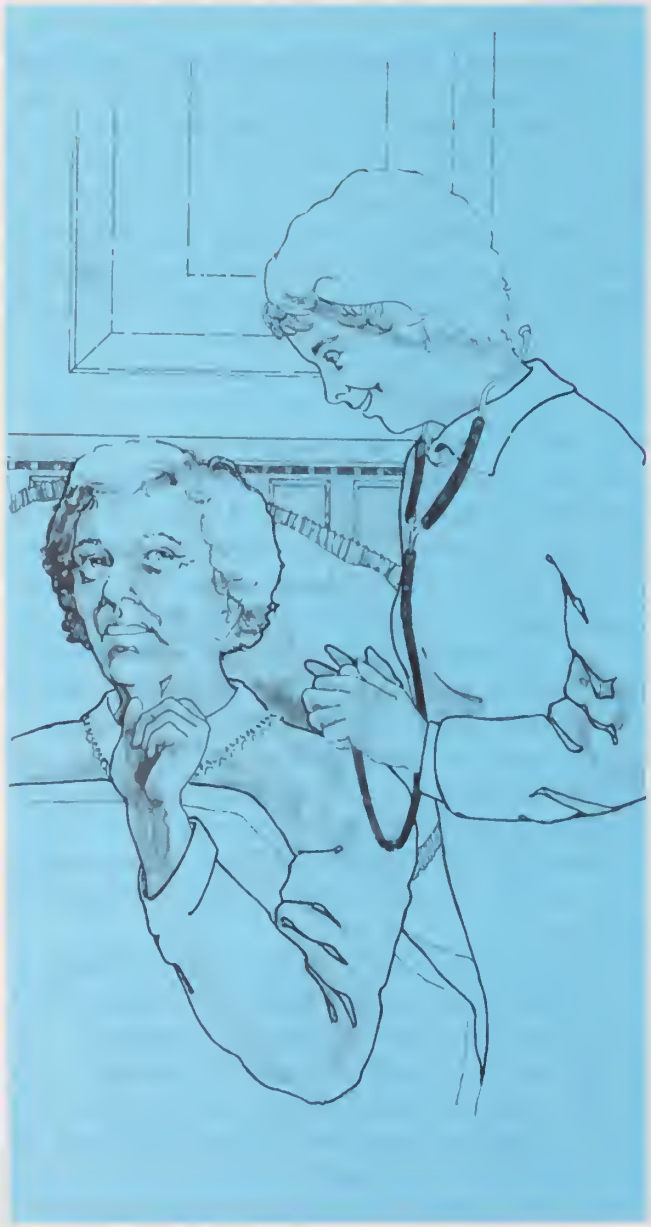
If you need part-time skilled health care in your home for the treatment of an illness or injury, Medicare can pay for covered home health visits furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapuetic services, such as physical therapy in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare can pay for home health visits only if **all** of the following four conditions are met:

(1) the care you need includes intermittent part-time skilled nursing care, physical therapy, or speech therapy,
(2) you are confined to your home,
(3) a doctor determines you need home health care and sets up a home health plan for you, and
(4) the home health agency providing services is participating in Medicare.

Once these conditions are met, either hospital insurance or medical insurance can pay for all medically necessary home health visits. When you no longer need part-time skilled nursing care, physical therapy, or speech therapy, Medicare can continue to pay for home health visits **if** you need occupational therapy.

Medicare does not cover general household services, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.



Home health services covered by Medicare

Medicare **can** pay for these services.

- Intermittent part-time, skilled nursing care
- Physical therapy
- Speech therapy

If you need intermittent part-time skilled nursing care, physical therapy, or speech therapy, Medicare can also pay for:

- Occupational therapy
- Part-time services of home health aides
- Medical social services
- Medical supplies
- Durable medical equipment (80% of approved cost)

Home health services not covered by Medicare

Medicare **cannot** pay for these services.

- Full-time nursing care at home
- Drugs and biologicals
- Meals delivered to your home
- Homemaker services
- Blood transfusions

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover.

The home health agency will submit the claim for payment. You don't have to send in any bills yourself.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19.)

HOSPICE CARE

Medicare hospital insurance can help pay for hospice care if all of the following three conditions are met:

(1) a doctor certifies that a patient is terminally ill,
(2) a patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness, and
(3) care is provided by a Medicare-certified hospice program.

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

Special benefit periods apply to hospice care. Hospital insurance can pay for a maximum of two 90-day periods and one 30-day period. (If a patient still needs hospice services after hospice benefit periods are exhausted, the hospice must continue care unless the patient no longer wants hospice services.)

During a hospice benefit period, Medicare pays the full cost of all covered services for the terminal illness. There are no deductibles or co-payments except for part of the cost of outpatient drugs and inpatient respite care.

Respite care is a short-term inpatient stay which may be necessary for the patient in order to give temporary relief to the person who regularly assists with home care. Inpatient respite care is limited each time to stays of no more than five days in a row.

The patient is responsible for 5 percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays 5 percent of the cost, up to a total of $540 (1988 amount) during a period that begins when a hospice plan is first chosen and ends 14 days after such care is cancelled.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

Services covered when provided by a hospice

Medicare hospital insurance **can** pay for these services:

- Nursing services
- Doctor's services
- Drugs, including outpatient drugs for pain relief and symptom management
- Physical therapy, occupational therapy and speech-language pathology
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Short-term inpatient care, including respite care
- Counseling

Some services not covered when you receive care from a hospice

Medicare hospital insurance **cannot** pay for these services:

- Treatments other than for pain relief and symptom management of a terminal illness
- Five percent of the cost of outpatient drugs or $5 per prescription, whichever is less
- Five percent of the cost of inpatient respite care, up to a total of $540 (1988 amount) during the period described on this page.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 19).

MEDICAL INSURANCE

This section tells you about:

YOUR MEDICARE MEDICAL INSURANCE

Medicare medical insurance can help pay

for (1) doctor's services, (2) outpatient hospital care, (3) outpatient physical therapy and speech pathology services, (4) home health care, and (5) many other health services and supplies which are not covered by Medicare hospital insurance.

The following sections will tell you more about these different kinds of care, the services that are and are not covered by medical insurance, and what part of your medical expenses Medicare can pay.

DEDUCTIBLE AND COINSURANCE AMOUNTS

There is a basic payment rule under medical insurance. After you have $75 in approved charges (see below) for covered medical expenses in 1988, medical insurance generally will pay 80 percent of the approved charges for any additional covered services you receive during the rest of the year. You are responsible for the remaining 20 percent.

The first $75 in covered expenses is called the medical insurance deductible. You need to meet this $75 deductible only once during the year. The deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you might receive.

The deductible applies to your expenses related to doctors and suppliers. Suppliers are persons or organizations other than doctors or health care facilities that furnish equipment or services covered by medical insurance.

APPROVED OR "REASONABLE" CHARGES

Medicare medical insurance payments are based on what the law defines as "reasonable charges" or the amounts approved by the Medicare carrier. Because of the way the approved amounts are determined and because of high rates of inflation in medical care prices, the charges approved are often less than the actual charges billed by doctors and suppliers. Medical insurance can pay only 80 percent of the approved charge even if it is less than the actual charge.

When a medical insurance claim is submitted, the carrier compares the actual charge shown on the claim with the customary and prevailing charges for that service. The charge approved by the carrier will be either: the customary charge (the charge most frequently made by the doctor or supplier for each item or service); the prevailing charge based on all the customary charges in the locality for each type of service; or the actual charge, whichever is the lowest.

There are two ways that payments are made under Medicare medical insurance. **The medical insurance payment can be made directly to the doctor or supplier through a method called assignment.** Or, the medical insurance **payment can be made to you.**

ASSIGNMENT

The assignment method, in which the doctor or supplier receives the medical insurance payment directly from Medicare, can save you time and money. When the assignment method is used, the doctor or supplier agrees to accept the charge approved by the Medicare carrier for the covered services. Medicare pays your doctor or supplier 80 percent of the approved charge, after subtracting any part of the $75 deductible you have not met. The doctor or supplier can charge you only for the part of the $75 deductible you had not met and for the co-insurance, which is the remaining 20 percent of the approved charge. Of course, your doctor or supplier also can charge you for any services that Medicare does not cover.

If your doctor does **not** accept assignment, Medicare pays you 80 percent of the approved charge, after subtracting any part of the $75 deductible you haven't met. The doctor or supplier can bill you for his or her actual charge even if it is more than the charge approved by the carrier.

Above are examples of the two payment methods (in both examples, the $75 deductible has already been met).

PARTICIPATING DOCTORS AND SUPPLIERS

Due to a change in the Medicare law, doc-

	Actual Charge	Medicare Approved Charge	Medicare Pays	You are Responsible for
Doctor Accepts Assignment	$500	$400	$320 (80% of approved charge)	$80 (20% of approved charge)
*Doctor Does Not Accept Assignment	$500	$400	$320 (80% of approved charge)	$180 (difference between actual charge and approved charge)

* Medicare law requires doctors who do not take assignment to give you a written estimate of your out-of-pocket costs if the total charge is $500 or more.

tors and suppliers can now sign agreements to become **Medicare-participating** doctors or suppliers. This means that they have agreed in advance to accept assignment on **all** Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year.

The names and addresses of Medicare-participating doctors and suppliers are listed in the "Medicare-Participating Physician/Supplier Directory." This directory can be obtained free of charge from your Medicare carrier (see page 28). Also, this directory is available for review in all Social Security offices, State and area offices of the Administration on Aging, and in most hospitals. In addition, Medicare-participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

EXPLANATION OF MEDICARE BENEFITS NOTICE

After you or the doctor or supplier sends in a medical insurance claim, Medicare will send you a notice called *Explanation of Medicare Benefits* to tell you the decision on the claim.

This notice shows what services were covered, what charges were approved, how much was credited toward your $75 yearly deductible, and the amount Medicare paid. Please examine the notice carefully. If you believe payment was made for a service or supply you didn't receive, or the payment is otherwise questionable, you may write to the carrier that handled your claim.

If you wish to call the carrier, a toll-free number is contained on the notice and on pages 28-32 of this handbook.

COVERED DOCTORS' SERVICES

Medicare medical insurance can help pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location in the U.S. Your medical insurance can also help pay for doctors' services you receive in connection with covered inpatient care in a Canadian or Mexican hospital. See page 7 to find out about care in Canadian and Mexican hospitals.

Major doctors' services covered by medical insurance

Medicare medical insurance **can** help pay for these services.

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures that are part of your treatment
- Radiology and pathology services by doctors while you are a hospital inpatient

- Other services which are ordinarily furnished in the doctor's office and included in his or her bill, such as:
  - — X-rays
  - — Services of your doctor's office nurse
  - — Drugs and biologicals that cannot be self-administered
  - — Transfusions of blood and blood components
  - — Medical supplies
  - — Physical therapy and speech pathology services

Some doctors' services not covered by medical insurance

Medicare medical insurance **cannot** pay for these services:

- Routine physical examinations and tests directly related to such examinations
- Routine foot care
- Eye or hearing examinations for prescribing or fitting eyeglasses or hearing aids
- Immunizations (except pneumococcal vaccinations or immunizations required because of an injury or immediate risk of infection)
- Cosmetic surgery unless it is needed because of accidental injury or to improve the function of a malformed part of the body

Outpatient treatment of mental illness

Doctors' services you receive for outpatient treatment of a mental illness are covered under a special payment rule, **but the maximum amount medical insurance can pay in 1988 for these services is $450 in a year.** The medical insurance payment would be less than $450 if charges for these services are used to meet part or all of your $75 deductible.

Chiropractors' services

Medical insurance helps pay for only one kind of treatment furnished by a licensed and Medicare-certified chiropractor. The **only** treatment that can be covered is manual manipulation of the spine to correct subluxation that can be demonstrated by X-ray. Medical insurance does **not** pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

Podiatrists' services

Medical insurance can help pay for any covered services of a licensed podiatrist, including the removal of plantar warts. Treatment of mycotic toenails (a fungus infection) is limited to once every 60 days unless the medical necessity for more frequent treatment is documented by the patient's physician or podiatrist.

Medical insurance generally does **not** cover routine foot care such as hygienic care; treatment for flat feet or other structural misalignments of the feet; and removal of corns, calluses, and most warts. But, medical insurance can help pay for routine foot care **if** you have a medical condition affecting the lower limbs (such as severe diabetes) which requires that a medical condition affecting the lower limbs (such as severe diabedes) which requires that such care can be performed by a podiatrist or a doctor of medicine or osteopathy.

Dental care

Medical insurance can help pay for dental care **only** if it involves (1) surgery of the jaw or related structures, (2) setting fractures of the jaw or facial bones, or (3) services that would be covered when provided by a doctor. If you need to be hospitalized because of the severity of a dental procedure, Medicare can cover your hospital stay even if the dental care itself is not covered by Medicare.

Care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting the teeth generally are **not** covered.

Optometrists' services

Medicare will help pay for the vision care services of optometrists, if the services are among those already covered by Medicare and if the optometrist is legally authorized to perform such services in your State. However, Medicare will **not** pay for routine eye exams, and it will not pay for eyeglasses or corrective

lenses unless they are prosthetic lenses that replace the natural lens of the eye. (See page 20.)

SECOND OPINION BEFORE SURGERY

Sometimes your doctor will recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get a second doctor's opinion to help you decide about surgery. Medical insurance will help pay for a second opinion in the same way it pays for other services by doctors.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call Medicare's Second Opinion Referral Center for the names and phone numbers of doctors in your area who provide second opinions. The toll-free number is 1-800-638-6833 (in Maryland 1-800-492-6603).

Peer Review Organizations (see page 1) have the authority to require second opinions for certain elective surgical procedures. The **PRO** will notify you if it determines that a second opinion is necessary. The cost of the second opinion will be paid in full by Medicare.

OUTPATIENT HOSPITAL SERVICES

Medicare medical insurance helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury.

When you go to a hospital for outpatient services, be sure to show the people there your most recent *Explanation of Medicare Benefits* notice. From this form, they usually can tell how much of the $75 deductible you have met.

The hospital will always file the claim for medical insurance payment. Medical insurance pays the hospital 80 percent of the approved amount for the covered services you received, after subtracting any of the $75 deductible you have not met. The hospital will charge you for the part of the deductible you had not met plus 20 percent of the remaining approved amount.

If the hospital cannot tell how much of the $75 deductible you have met and the charge for the services you received is less than $75, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible you have not met, and any medical insurance payments due will be paid directly to you.

Under certain conditions, medical insurance can also help pay for emergency outpatient care you receive from a non-participating hospital.

Major outpatient hospital services covered by medical insurance

Medicare medical insurance helps pay for these services:

- Services in an emergency room or outpatient clinic
- Laboratory tests billed by the hospital
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Drugs and biologicals which cannot be self-administered
- Blood transfusions furnished to you as an outpatient

Some outpatient hospital services not covered by medical insurance

Medicare medical insurance **cannot** pay for these services:

- Routine physical examinations and tests directly related to such examinations
- Eye or ear examinations to prescribe or fit eyeglasses or hearing aids
- Immunizations (except pneumococcal and Hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection)
- Routine foot care

Outpatient physical therapy and speech pathology services

You may receive physical therapy or speech pathology services as part of your treatment in a doctor's office. In this case, the doctor must include the charge for the services in the bill. Medical insurance will pay 80 percent of the approved charges after the $75 deductible has been met. Either you or the doctor can submit the claim as described on page 22.

Medicare medical insurance can also help pay for medically necessary outpatient physical therapy or speech pathology services in two other ways, if all the following three conditions are met:

(1) your doctor must prescribe the service,
(2) your doctor or therapist must set up a plan of treatment, and
(3) your doctor must periodically review that plan.

You may receive services directly from an independently practicing, Medicare-certified physical therapist in his or her office or in your home if such treatment is prescribed by a doctor. But, **the maximum amount medical insurance can pay for these services is $400 a year**. The medical insurance payment would be less than $400 if charges for these services are used to meet part or all of your $75 deductible. Either you or the physical therapist can submit the claim as described on page 22.

You may receive physical therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare. The organization providing services always submits the claim and may only charge you for any part of the $75 deductible you had not met, 20 percent of the remaining approved amount, and any noncovered services.

Outpatient surgical services

Some surgery can be performed safely on an outpatient basis, avoiding the need for an inpatient hospital stay. Medicare can pay for certain specified outpatient surgical procedures performed in a Medicare-certified outpatient surgical center. The center can be affiliated with a hospital or it can be independent, but it must provide only outpatient surgery services and must have an agreement with Medicare to do so.

After you have met the $75 deductible, Medicare will pay 80 percent of your surgeon's and anesthesiologist's approved charge for services if the physician accepts assignment. Such services can include pre- and post-operative care furnished on an outpatient basis in an outpatient surgical center in a hospital.

To find out if a particular procedure qualifies for these special payment rules, get in touch with your Medicare carrier.

Comprehensive outpatient rehabilitation facility services

Under certain circumstances, Medicare can help pay for outpatient services you receive

from a comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services, and you must go to the facility to receive the services. For services, other than mental health services, you are responsible only for the annual deductible and 20 percent of the facility's customary charges. The maximum Medicare can pay for outpatient treatment of a mental illness is $450 a year for physicians' services and CORF services combined.

OTHER COVERED SERVICES AND SUPPLIES

Medicare medical insurance also helps pay for other services and supplies which are described in this section. Medical insurance usually will pay 80 percent of the approved charges for these covered services and supplies after you have met the $75 deductible. Usually, when these services and supplies are furnished by a hospital, skilled nursing facility, or home health agency, it will make the claim for medical insurance payment. Otherwise, you or the supplier submits the claim. Page 22 tells you how medical insurance claims are submitted.

Blood

Medical insurance can help pay for blood and blood components you receive as an outpatient or as part of other covered services, **except for any nonreplacement fees charged for the first 3 pints or units received in each calendar year.** After you have met the $75 deductible, medical insurance pays 80 percent of the approved charges for blood starting with the fourth pint in a calendar year.

Independent laboratory services

Medical insurance can pay the full approved fee for covered diagnostic tests provided by independent laboratories that accept Medicare assignment. **If a doctor prescribes tests from a laboratory which does not accept assignment, Medicare cannot pay for the tests. So that Medicare can pay for your tests, be sure to ask the doctor about using a laboratory which accepts assignment.** Medicare will not pay for clinical diagnostic tests furnished by the physician himself unless he accepts assignment for the tests. Also, the laboratory must be certified by Medicare for the services you receive. Not all laboratories are certified by Medicare and some laboratories are certified only for certain kinds of tests. Your doctor can usually tell you which laboratories are certified and whether the tests he or she is prescribing from a certified laboratory are covered by medical insurance.

Ambulance transportation

Medical insurance can help pay for medically necessary ambulance transportation but **only** if (1) the ambulance, equipment, and personnel meet Medicare requirements, and (2) transportation in any other vehicle could endanger the patient's health.

Under these conditions, medical insurance can help pay for ambulance transportation to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to your home. Also, if you are an inpatient in a hospital or skilled nursing facility which cannot provide a medically necessary service you need, medical insurance can help pay for roundtrip ambulance transportation to the nearest appropriate facility.

Medical insurance **cannot** pay for ambulance use from your home to a doctor's office.

Medical insurance usually can help pay for ambulance transportation only in your local area. But, if there are no local facilities equipped to provide the care you need, medical insurance will help pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If you choose to go to another institution that is farther away, Medicare payment still will be based on the reasonable charge for transportation to the closest facility.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital (see page 7) can also be covered by medical insurance.

Prosthetic devices

Medical insurance helps pay for prosthetic devices needed to substitute for an internal body organ. These include heart pacemakers, Medicare-approved corrective lenses needed after a cataract operation, colostomy or ileostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medical insurance can also help pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Orthopedic shoes are covered **only** when they are part of leg braces and the cost is included in the orthopedist's charge. Dental plates or other dental devices are not covered.

Durable medical equipment

Medical insurance can help pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes for use in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

The decision to rent or buy durable medical equipment is yours. However, the Medicare carrier that handles medical insurance claims in your area is required to review all claims for durable medical equipment. The carrier will notify you if it decides that rental or purchase would be less costly for you and the Medicare program.

When making your decision to rent or buy, ask your doctor about how long you will need the equipment and ask the equipment supplier or retailer for a comparison of the purchase prices and the estimated rental payments for the period of time you expect to need the equipment.

Portable diagnostic x-ray services

Medical insurance helps pay the approved charges for portable diagnostic X-ray services you receive in your home if they are ordered by a doctor and if they are provided by a Medicare-certified supplier.

Medical supplies

Medical insurance can also help pay for surgical dressings, splints, casts, and similar medical supplies ordered by a doctor in connection with your medical treatment. This does **not** include adhesive tape, antiseptics, or other common first-aid supplies.

Pneumococcal vaccine

Medical insurance will pay the full approved charges for pneumococcal vaccine and its administration. The $75 deductible does not apply to this service.

Hepatitis B vaccine

Medicare will help pay for hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

YOUR RIGHT OF APPEAL

This section tells you about:

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision.

The notice you receive from Medicare which tells you of the decision made on a claim will also tell you exactly what appeal steps you can take. If you ever need more information about your right to appeal and how to request it, call any Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization in your State. The following is a brief summary of the different Medicare appeals processes.

APPEALING DECISIONS BY PEER REVIEW ORGANIZATIONS (PROs)

Peer Review Organizations make decisions on the need for hospital care (see page 1 for a description of PROs). Whenever you are admitted to a Medicare-participating hospital, you will be given "An Important Message From Medicare," which briefly describes your appeal rights as a hospital patient and supplies the name, address, and phone number of the PRO in your State.

If you disagree with the decision of a PRO you can appeal by requesting a reconsideration. Then, if you disagree with the PRO's reconsideration decision and the amount in question is $200 or more, you can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

APPEALING ALL OTHER HOSPITAL INSURANCE DECISIONS

Appeals of decisions on all other services covered under Medicare hospital insurance (skilled nursing facility care, home health care, hospice services, and some inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries. If you disagree with the intermediary's initial decision, you may request a reconsideration. The request can be submitted directly to the intermediary or through your Social Security office. If you disagree with the intermediary's reconsideration decision and the amount in question in $100 or more, you can request a hearing by an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

APPEALING DECISIONS BY HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AND COMPETITIVE MEDICAL PLANS (CMPs)

If you are a member of a Medicare-certified Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP), you have the same appeal rights that all other Medicare beneficiaries have. Also, Federal law requires Medicare-certified HMOs and CMPs to provide a full, written explanation of appeal rights to all members at the time of enrollment. If you are a member of such a plan and you have not received a written explanation of your appeal rights, you should request one from your plan's membership office or write to the Health Care Financing Administration.

APPEALING DECISIONS ON MEDICAL INSURANCE CLAIMS

Under Medicare medical insurance, either you, your doctor, or your supplier submits the claim for payment. Medicare will send you an explanation of the decision made on the claim on a form called "An Explanation of Medicare Benefits" (EOMB). The form also explains how you can appeal denials or payment decisions with which you disagree, and gives the name, address, and State-wide toll-free number of the carrier (the names and addresses of the carriers and the areas they serve are also listed at the back of this Handbook on pages 28 to 32). If you disagree with the decision on your claim, you can ask the carrier to review it. Then, if you disagree with the carrier's written explanation of its review decision and the amount in question is $100 or more, you can request a hearing by the carrier. (To reach the $100 amount, you can count other claims that have been reviewed within the past six months.)

If you disagree with the carrier hearing decision and the amount in question is $500 or more, you are entitled to a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

WHAT MEDICARE DOES NOT COVER

CARE THAT IS CUSTODIAL

Care is considered custodial when it is primarily for the purpose of meeting personal

needs and could be provided by persons without professional skills or training. Much of the care provided in nursing homes or by home agencies to persons with chronic, long-term illnesses or disabilities falls into this category. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.

CARE THAT IS NOT REASONABLE AND NECESSARY

If a doctor places you in hospital or skilled nursing facility when the kind of care you need could be provided elsewhere, your stay would not be considered reasonable and necessary. So Medicare could not cover your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments would end when further inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you or you visit him or her for treatment more often than is medically necessary, Medicare would not cover the "extra" visits. Medicare cannot cover more services than are reasonable and necessary for your treatment. Any decision of this kind is always based on professional medical advice.

SERVICES NOT COVERED

This alphabetical list shows most of the major services and supplies that Medicare usually does not pay for. However, some of these items can be covered by Medicare under certain conditions described on the pages indicated.

Acupuncture

Chiropractic services (see page 14)

Christian Science practitioners' services

Cosmetic surgery (see page 14)

Custodial care

Dental care (see page 14)

Drugs and medicines you buy yourself with or without a doctor's prescription (see page 11)

Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses (see page 14)

Foot care that is routine (see page 14)

Foreign health care (see page 7)

Hearing aids and hearing examinations for prescribing, fitting, or changing hearing aids

Homemaker services (see page 10)

Immunizations except pneumococcal and Hepatitis B vaccinations or immunizations required because of any injury or immediate risk of infection

Injections which can be self-administered, such as insulin

Long term care (nursing homes)

Meals delivered to your home

Naturopath's services

Nursing care on a full-time basis in your home

Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge

Personal convenience items that you request such as a phone or television in your room at a hospital or skilled nursing facility

Physical examinations that are routine (for example, yearly physical examinations) and tests directly related to such examinations

Private duty nurses

Private room (see page 9)

Services performed by immediate relatives or members of your household

Services which are not reasonable and necessary

Services payable by any of the following:

- Workers' Compensation (including black lung benefits)
- Automobile or liability insurance
- Employer group health plans when primary payer (see page 23)
- Employer group health plans for people entitled to Medicare solely on the basis of end stage renal disease (only applies to first year of coverage)
- Another government program

WAIVER OF BENEFICIARY LIABILITY

There is a provision in the Medicare law that says you will not be held responsible for paying for health care services if you could

not reasonably be expected to know that the services were not covered by Medicare. This provision is called "waiver of beneficiary liability." Waiver applies only when the care is not covered because it was custodial care or was not reasonable or necessary for diagnosis or treatment. The waiver provision does not apply to medical insurance claims unless the doctor or other person who furnished the services agreed to payment under the assignment method (see page 12).

GETTING THE PART OF MEDICARE YOU DO NOT HAVE

This section tells you about:

MEDICAL INSURANCE

If you have Medicare hospital insurance but do not have the medical insurance part of Medicare, you can sign up for medical insurance during a general enrollment period. A general enrollment period is held January 1 through March 31 each year. Your protection will begin July 1 of the year you enroll. If you enroll during a general enrollment period, your monthly premium will be 10 percent higher than the basic premium for each 12-month period you could have had medical insurance but were not enrolled. (The basic medical insurance premium is $24.80 a month through December 31, 1988. This amount may change next January 1). Also, see this page for additional information on delayed enrollment.

HOSPITAL INSURANCE

Some individuals 65 or older have Medicare medical insurance, but do not meet the requirements for premium-free hospital insurance. If you are in this category, you can get hospital insurance by paying a monthly premium. (This premium applies only to persons who are not entitled to hospital insurance through the Social Security or the Railroad Retirement system. The basic hospital insurance premium is $234 a month through December 31. This amount may change next January 1.)

You can sign up for premium hospital insurance during a general enrollment period January 1 through March 31 each year. If you enroll during a general enrollment period that begins more than one year after your 65th birthday, your monthly premium will be 10 percent higher than the basic premium amount. Your protection will not begin until July 1 of the year you enroll.

For more information about premium amounts, premium surcharges, and how to get the part of Medicare you do not have, contact your Social Security office.

EVENTS THAT CAN CHANGE YOUR MEDICARE PROTECTION

This section tells you about:

WHEN PROTECTION ENDS FOR PERSONS 65 AND OLDER

If you have Medicare hospital insurance based on your husband's or wife's work record, your protection will end if you and your spouse divorce before your marriage has lasted 10 years. If you have hospital insurance based on your own work record, your protection will continue as long as you live.

Your medical insurance protection will stop if your premiums are not paid or if you voluntarily cancel. If you are thinking about cancelling your medical insurance, remember that you may not be able to get private insurance that offers the same protection. Also, if you cancel your medical insurance and then later decide to re-enroll, your premium may be higher and your protection will not begin again until July 1 of the year you re-enroll (unless you qualify for a special enrollment period as described on page 23).

If you are buying Medicare hospital insurance as described in the previous column, you will lose it if you cancel your medical insurance. People who buy hospital insurance

must enroll and pay the premium for medical insurance. But, you can cancel hospital insurance and still continue your medical insurance.

If you want more information about cancelling your Medicare protection, get in touch with any Social Security office.

WHEN PROTECTION ENDS FOR THE DISABLED

If you have Medicare because you are disabled, your protection will end if you recover from your disability before you are 65. If you go to work but are still disabled, your Medicare protection may continue for up to 48 months after you begin working.

If you ever want to cancel your medical insurance, call any Social Security office.

WHEN PROTECTION ENDS FOR THOSE WITH PERMANENT KIDNEY FAILURE

If you have Medicare because of permanent kidney failure, your protection will end 12 months after the month maintenance dialysis treatment stops or 36 months after the month you have a kidney transplant.

Your medical insurance protection could stop before that for failure to pay premiums or if you decide to cancel. Call any Social Security office if you ever want to cancel your insurance protection.

HOW TO SUBMIT MEDICAL INSURANCE CLAIMS

This section will tell you about:

SUBMITTING YOUR MEDICAL INSURANCE CLAIM

A Patient's Request for Medicare Payment form, also called Form 1490S (see pages 26 and 27 for a sample form 1490S), must be submitted to the Medicare carrier in order for medical insurance to pay for covered services of doctors and suppliers. All Social Security offices and Medicare carriers, and most doctors' offices, have copies of the form. Instructions on how to fill it out are on the back of the form.

If the doctor or supplier is Medicare participating or uses the assignment method of payment, he or she submits the claim, and you do not have to use the 1490S form.

If the doctor or supplier does not accept assignment, you submit the claim, using the 1490S form. Complete **and** sign the form and attach itemized bills for the services you received.

An itemized bill **must** show (1) the date you received the services, (2) the place where you received the services, (3) a description of the services, (4) the charge for each service, (5) the doctor or supplier who provided the services, and (6) your name **and** your health insurance claim number, **including** the letter at the end of the number. If the bill doesn't include all of this information, your payment will be delayed. It is also helpful if the nature of your illness (diagnosis) is shown on the bill. If you are submitting a claim for the rental or purchase of durable medical equipment, you must include the bill from the supplier **and** the doctor's prescription. The prescription must show the equipment you need, the medical reason for the need, and an estimate of how long the equipment will be medically necessary.

You may submit several itemized bills with a 1490S form. It doesn't matter whether all the bills are from one doctor or supplier or from different people who gave you services. You can send in the bills either before or after you pay them.

Before any medical insurance payment can be made, your record must show that you have met the deductible. So, as soon as your bills come to $75, send them to your Medicare carrier with a 1490S form. Page 24 will tell you where to send your claim. Once you have met the $75 deductible, we suggest that

you send in your future bills for covered services as soon as you get them so that Medicare payment can be made promptly.

If all your medical bills for the year amount to less than $75, medical insurance cannot pay any part of your bills for the year.

It's a good idea to keep a record of your medical insurance claim in case you ever want to inquire about it. Before you send in a claim, write down the date you mail it, the services you received, the date and charge for each service, and the name of the person who provided each service.

WHEN OTHER INSURANCE PAYS FIRST

Medicare has special rules that apply to beneficiaries who have employer health group plan coverage through their employment or the employment of a spouse.

If any of the following insurance situations applies to you, please notify your doctor, hospital, or other provider of services and file your claim with the other insurer first.

When you or your spouse continue to work

Employers with 20 or more employees are required to offer workers and their spouses age 65 and over the same health insurance benefits offered to younger workers. In such situations you have the option to accept or reject your employer's health plan. **If you accept it, Medicare will become the secondary payer.** If you reject your employer's health plan, Medicare will remain the primary health insurance payer. If you elect Medicare to be the primary payer, your employer cannot provide you with Medicare supplemental coverage.

If you are disabled and under age 65

For employed disabled beneficiaries who choose coverage under their employer's health plan (or the health plan of an employed spouse), Medicare will become the secondary payer. This provision applies to employees of businesses that employ 100 or more employees. Employees of smaller firms and their dependents may be covered if special conditions apply.

Delayed enrollment under Medicare medical insurance

When you are covered by an employer health plan and Medicare is your secondary payer (as described in the two preceding sections) you may be able to delay enrollment in Medicare's medical insurance without penalty. Your Social Security office can give you more information on **special enrollment periods** or delayed enrollment in Medicare's medical insurance.

Other situations where Medicare is the secondary payer

If you are disabled as a result of military service or a work-related illness or injury, services provided as treatment of that illness or injury should be covered by your worker's compensation or veteran's benefits. It is important that your Medicare claim form note that the treatment is related to a service or work-related illness or injury even if the injury or illness occurred in the past.

Medicare is a secondary payer for beneficiaries who are eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD) for up to 1 year, if they have employer group health plan coverage.

Medicare also serves as the secondary payer in cases where automobile medical or no fault or liability insurance is available as the primary payer.

For more information, contact your employer or ask any Social Security office for a free copy of *Medicare and Employer Health Plans*.

If you are entitled to both Medicare and veterans benefits

An individual who is entitled to veterans benefits **and** to Medicare benefits may choose to receive treatment under either program. Under the law, Medicare cannot pay for services furnished by VA hospitals and VA medical facilities, except for certain emergency hospital services. Also, if a veteran receives treatment in a non-VA hospital or from a non-VA physician and the VA has authorized payment for the services, Medicare cannot pay for them. Medicare can pay for covered services a veteran receives from non-VA hospitals and physicians if the VA has not authorized payment for the services.

Since July 1986, the VA has been charging copayments to some veterans with non-service connected conditions for treatment in a VA hospital or medical facility, or for VA authorized treatment by non-VA sources. The VA charges copayments when the veteran's income exceeds a particular level. If the VA charges the veteran a copayment for **VA authorized care by a non-VA physician or hospital**. Medicare may be able to reimburse the veteran, in whole or in part, for his or her VA copayment obligation. But Medicare may not reimburse a veteran for VA copayments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient **hospital** services. In the latter case, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

For further information, contact your Medicare intermediary or carrier.

SUBMITTING CLAIMS FOR A PERSON WHO DIES

When someone who has Medicare dies, any hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency or hospice that provided covered services.

For services covered under medical insurance, some special rules apply, depending on whether or not the doctor's or supplier's bill has been paid.

If the bill was paid by the patient or with funds from the patient's estate, payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has not been paid and the doctor or supplier does not accept assignment, the medical insurance payment can be made to the person who has legal obligation to pay the bill for the deceased patient. The person can claim the medical insurance payment either before or after paying the bill.

The Medicare carrier or any Social Security office can provide additional information about how to claim a medical insurance payment after a patient dies.

TIME LIMITS

Under the law, there are some time limits for submitting medical insurance claims. For medical insurance to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

For service you receive between	Your claim must be submitted by
Oct. 1, 1986, & Sept. 30, 1987	Dec. 31, 1988
Oct. 1, 1987, & Sept. 30, 1988	Dec. 31, 1989
Oct. 1, 1988, & Sept. 30, 1989	Dec. 31, 1990

WHERE TO SEND YOUR CLAIMS

The list on pages 28 - 32 gives the names, addresses, and phone numbers of the Medicare carriers selected to handle claims for an entire State. But some carriers handle claims for only part of the State. To find out where to send your medical insurance claim, look in the list for the State **where you received the services**.

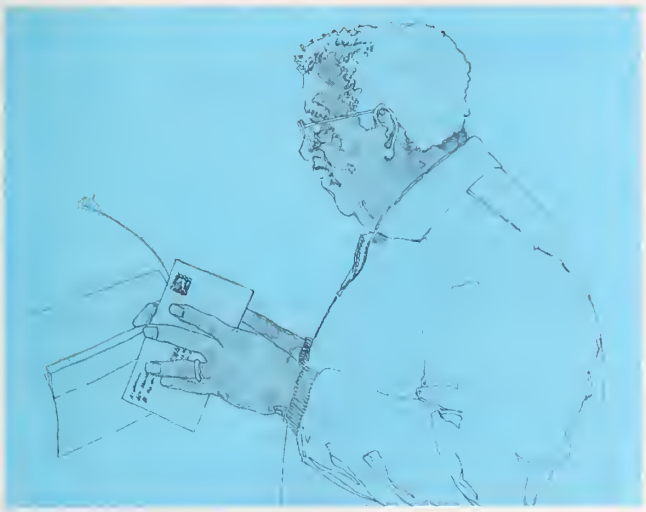
Under the name of the State, you will find the name of the carrier that will handle your claim. If there is more than one carrier in the State, look for the **county** where you received services to find the carrier that will handle your claim. (See page 22 to find out how to submit medical insurance claims.)

If you are not sure where to send your first claim and happen to send it to the wrong office, your claim will be sent to the right place.

Whenever you send in a claim, be sure to include the word "Medicare" in the carrier's address on the envelope. Also, be sure to put **your** return address and a stamp on the envelope.

After you make a claim, the carrier will usually send you another 1490S form for your next claim. The form will usually show the carrier's name and address in the top right hand corner. If you ever need to file a medical insurance claim and don't have a claim form, you can use the one on page 26 or you can get one by phoning the Medicare carrier or a Social Security office.

NOTE: If you are entitled to Medicare under the railroad retirement system, send your medical insurance claims to The Travelers Insurance Company office which serves your region. Regional offices of The Travelers are listed in *Your Medicare Handbook for Railroad Retirement Beneficiaries*, which is available at any railroad retirement office.



FORM APPROVED
OMB NO. 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)

SEND COMPLETED FORM TO:

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or PO Box — Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number (Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the Illness or Injury for which Patient Received Treatment

4b Was condition related to:
A. Patient's employment ☐ Yes ☐ No
B. Accident ☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance No.

Policyholders Name:

NOTE: If you DO NOT want payment information on this claim released, put an (X) here ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME

6 Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Form HCFA-1490S (2-87) DEPARTMENT OF HEALTH AND HUMAN SERVICES—HEALTH CARE FINANCING ADMINISTRATION

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card. (Last Name, First Name, Middle Name)

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in Block 6 too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in Block 6. You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service —Doctor's Office —Outpatient Hospital —Patient's Home —Independent Laboratory —Nursing Home —Inpatient Hospital
- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is shown on the physician's bill. If not, be sure you have completed Block 4 of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

Note: The toll-free or 800 numbers listed below can be used only in the states or service areas indicated. Also listed are the local commercial numbers for some carriers.

Alabama
Medicare/Blue Cross-Blue Shield of Alabama
P.O. Box C-140 Birmingham, Alabama 35283
1-800-292-8855
205-988-2244

Alaska
Medicare/Aetna Life & Casualty
200 S.W. Market St., P.O. Box 1998
Portland, Oregon 97207-1998
1-800-547-6333

Arizona
Medicare/Aetna Life & Casualty
P.O. Box 37200
Phoenix, Arizona 85069
1-800-352-0411
602-861-1968

Arkansas
Medicare/Arkansas Blue Cross and Blue Shield
A Mutual Insurance Company
P.O. Box 1418, Little Rock, Arkansas 72203
1-800-482-5525
501-378-2320

California
Counties of: Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
Medicare/Transamerica Occidental Life Insurance Co.
Box 54905 Terminal Annex
Los Angeles, California 90054
1-800-252-9020
213-748-2311

Rest of State: Medicare Claims Dept.
Blue Shield of California
Chico, California 95976
(In area codes 209, 408, 415, 707, 916)
1-800-952-8627
(In area codes 213, 619, 714, 805, 818)
1-800-848-7713
714-824-0900

Colorado
Medicare/Blue Shield of Colorado
700 Broadway, Denver, Colorado 80273
1-800-332-6681
303-831-2661

Connecticut
Medicare/The Travelers Ins. Co.
P.O. Box 5005
Wallingford, Connecticut 06493-5005
1-800-982-6819
(In Hartford) 203-728-6783

Delaware
Medicare/Pennsylvania Blue Shield
P.O. Box 65, Camp Hill, Pennsylvania 17011
1-800-851-3535

District of Columbia
Medicare/Pennsylvania Blue Shield
P.O. Box 100, Camp Hill, Pennsylvania 17011
1-800-233-1124

Florida
Medicare/Blue Shield of Fla. Inc.
P.O. Box 2525, Jacksonville, Florida 32231
1-800-333-7586
904-355-3680

Georgia
The Prudential Ins. Co. of America
Medicare Part B
P.O. Box 546, Buford, Georgia 30518
1-800-241-3081
404-945-1401

Hawaii
Medicare/Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
1-800-272-5242
808-524-1240

Idaho
EQUICOR, Inc.
P.O. Box 8048
Boise, Idaho 83707
1-800-632-6574
208-342-7763

Illinois
Medicare Claims
Blue Cross & Blue Shield of Illinois
P.O. Box 4422
Marion, Illinois 62959
1-800-642-6930
312-938-8000

Indiana
Medicare Part B
Associated Ins. Companies, Inc.
P.O. Box 7073
Indianapolis, Indiana 46207
1-800-622-4792
317-842-4151

Iowa
Medicare/Blue Shield of Iowa
636 Grand
Des Moines, Iowa 50309
1-800-532-1285
515-245-4785

Kansas
Counties of: Johnson, Wyandotte
Medicare/Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141
1-800-892-5900
816-561-0900

Rest of State: Medicare/Blue Shield of Kansas
P.O. Box 239
Topeka, Kansas 66601
1-800-432-3531
913-232-3773

Kentucky
Medicare-Part B
Blue Cross & Blue Shield of KY
100 East Vine St.
Lexington, Kentucky 40507
1-800-432-9255
606-233-1441

Louisiana
Blue Cross & Blue Shield of LA
Medicare Administration
P.O. Box 95024
Baton Rouge, Louisiana 70895-9024
1-800-462-9666
(In New Orleans) 504-529-1494
(In Baton Rouge) 504-272-1242

Maine
Medicare/Blue Shield of
Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-492-0919

Maryland
Counties of: Montgomery, Prince Georges
Medicare/Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, Pennsylvania 17011
1-800-233-1124

Rest of State: Maryland Blue Shield, Inc.
700 E. Joppa Road
Towson, Maryland 21204
1-800-492-4795
301-561-4160

Massachusetts
Medicare/Blue Shield of Massachusetts, Inc.
55 Accord Park Drive
Rockland, Massachusetts 02371
1-800-882-1228

Michigan
Medicare Part B
Michigan Blue Cross & Blue Shield
P.O. Box 2201, Detroit, Michigan 48231-2201
(In area code 313) 1-800-482-4045
(In area code 517) 1-800-322-0607
(In area code 616) 1-800-442-8020
(In area code 906) 1-800-562-7802
(In Detroit) 313-225-8200

Minnesota
Counties of: Anoka, Dakota, Filmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, Winona
Medicare/The Travelers Ins. Co.
8120 Penn Avenue
South Bloomington, Minnesota 55431
1-800-352-2762
612-884-7171

Rest of State: Medicare
Blue Shield of Minnesota
P.O. Box 64357, St. Paul, Minnesota 55164
1-800-392-0343
612-456-5070

Mississippi
Medicare/The Travelers Ins. Co.
P.O. Box 22545
Jackson, Mississippi 39225-2545
1-800-682-5417
601-956-0372

Missouri
Counties of: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth
Medicare/Blue Shield of Kansas City
P.O. Box 169, Kansas City, Missouri 64141
1-800-892-5900
816-561-0900

Rest of State: Medicare
General American Life Insurance Co.
P.O. Box 505, St. Louis, Missouri 63166
1-800-392-3070
314-843-8880

Montana
Medicare
Blue Shield of Montana, Inc.
P.O. Box 4310, Helena, Montana 59601
1-800-332-6146
406-444-8350

Nebraska
Medicare/Blue Shield of Iowa
P.O. Box 10479, Des Moines, Iowa 50306
1-800-633-1113
402-397-9182

Nevada
Medicare/Aetna Life & Casualty
P.O. Box 37230, Phoenix, Arizona 85069
1-800-528-0311

New Hampshire
Medicare
Blue Shield of Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-447-1142

New Jersey
Medicare
The Prudential Insurance Co. of America
P.O. Box 3000
Linwood, New Jersey 08221
1-800-462-9306

New Mexico
Medicare/Aetna Life & Casualty
P.O. Box 25500
Oklahoma City, Oklahoma 73125-0500
1-800-423-2925
(In Albuquerque) 505-843-7771

New York
Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare/Empire Blue Cross & Blue Shield
P.O. Box 4840, Grand Central Station
New York, New York 10163
1-800-442-8430
212-490-4444

County of: Queens
Medicare/Group Health, Inc.
P.O. Box A966, Times Square Station
New York, New York 10036
212-760-6790

Rest of State: Medicare
Blue Shield of Western New York
P.O. Box 5200
Binghamton, New York 13902-5200
607-772-6906
1-800-252-6550

North Carolina
The Prudential Insurance Co. of America
Medicare B Division
P.O. Box 2126
High Point, North Carolina 27261
1-800-672-3071
919-884-3400

North Dakota
Medicare/Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-247-2267
701-282-1100

Ohio
Medicare/Nationwide Mutual Ins. Co.
P.O. Box 57, Columbus, Ohio 43216
1-800-282-0530
614-249-7157

Oklahoma
Medicare/Aetna Life & Casualty
701 N.W. 63rd St., Suite 300
Oklahoma City, Oklahoma 73116-7693
1-800-522-9079
405-848-7711

Oregon
Medicare/Aetna Life & Casualty
200 S.W. Market St.
P.O. Box 1997
Portland, Oregon 97207-1997
1-800-452-0125
503-222-6831

Pennsylvania
Medicare/Pennsylvania Blue Shield
Box 65
Camp Hill, Pennsylvania 17011
1-800-382-1274

Rhode Island
Medicare/Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901
1-800-662-5170
401-861-2273

South Carolina
Medicare Part B
Blue Cross & Blue Shield of South Carolina
Fontaine Road Business Center
300 Arbor Lake Drive, Suite 1300
Columbia, South Carolina 29223
1-800-922-2340
803-754-0639

South Dakota
Medicare Part B
Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-437-4762

Tennessee
EQUICOR, Inc.
P.O. Box 1465
Nashville, Tennessee 37202
1-800-342-8900
615-244-5650

Texas
Medicare
Blue Cross & Blue Shield of Texas, Inc.
P.O. Box 660031
Dallas, Texas 75266-0031
1-800-442-2620

Utah
Medicare/Blue Shield of Utah
P.O. Box 30270, 2455 Parley's Way
Salt Lake City, Utah 84130-0270
1-800-426-3477
801-481-6196

Vermont
Medicare
Blue Shield of Massachusetts/Tri-State
P.O. Box 1010, Biddeford, Maine 04005
1-800-447-1142

Virginia
Counties of: Arlington, Fairfax;
Cities of: Alexandria, Falls Church, Fairfax
Medicare/Pennsylvania Blue Shield
P.O. Box 100, Camp Hill, Pennsylvania 17011
1-800-233-1124

Rest of State: Medicare/The Travelers Ins. Co.
P.O. Box 26463, Richmond, Virginia 23261
1-800-552-3423
804-254-4130

Washington
Medicare/Washington Physicians' Service
Mail to your local Medical Service Bureau
If you do not know which bureau handles your claim, mail to:

Medicare Washington Physicians' Service
4th and Battery Bldg., 6th floor
2401 4th Avenue, Seattle, Washington 98121

(In King County) 1-800-422-4087
(206) 464-3711
(In Spokane) 1-800-572-5256
(509) 536-4550
(In Kitsap) 1-800-552-7114
(206) 377-5576
(In Pierce) (206) 597-6530

Others: Collect if out of call area.

West Virginia
Medicare/Nationwide Mutual Insurance Co.
P.O. Box 57, Columbus, Ohio 43216
1-800-848-0106

Wisconsin
Medicare/WPS
Box 1787, Madison, Wisconsin 53701
1-800-362-7221
(In Madison) 608-221-3330
(In Milwaukee) 414-931-1071

Wyoming
EQUICOR, Inc.
P.O. Box 628, Cheyenne, Wyoming 82003
1-800-442-2371
307-632-9381

American Samoa
Medicare/Aetna Life & Casualty
P.O. Box 3947, Honolulu, Hawaii 96812
1-800-272-5242

Guam
Medicare/Aetna Life & Casualty
P.O. Box 3947, Honolulu, Hawaii 96812
1-800-272-5242
808-524-1240

Northern Mariana Islands
Medicare/Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

Puerto Rico
Medicare/Seguros De Servicio De
Salud De Puerto Rico
Call Box 71391 San Juan, Puerto Rico 00936
137-800-462-7385
809-759-9191

Virgin Islands
Medicare/Seguros De Servicio De
Salud De Puerto Rico
Call Box 71391 San Juan, Puerto Rico 00936
137-800-462-2970
809-759-9191

GLOSSARY OF MEDICARE-RELATED TERMS

actual charge—the amount a physician or supplier actually bills a patient for a particular medical service or supply. (This may differ from the customary, prevailing, and/or reasonable charges under Medicare.)

assignment—a process through which a doctor or supplier agrees to accept the Medicare program's payment as payment in full except for specific coinsurance and deductible amounts required of the patient.

carrier—a private insurance organization which contracts with the Federal government to handle claims from doctors and suppliers of services covered by Medicare medical insurance.

claim—a request to a carrier or intermediary by a beneficiary or a provider acting on behalf of a beneficiary for payment of benefits under Medicare.

co-insurance—a cost-sharing requirement which provides that a beneficary will assume a portion or percentage of the costs of covered services.

customary charge—the amount which a doctor or supplier most frequently charges for each separate service and supply furnished.

deductible—the amount of expense a beneficiary must first incur before Medicare begins payment for covered services.

home health agency—a public or private organization that specializes in giving skilled nursing services and other therapeutic services such as physical therapy in a beneficiary's home.

hospice—a program operated by a public agency or private organization which engages primarily in providing pain relief, symptom management, and supportive services for terminally ill people and their families.

hospital insurance—the part of Medicare which helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care.

intermediary—a private insurance organization which contracts with the Federal government to handle Medicare payment for services by hospitals, skilled nursing facilities, and home health agencies paid through the hospital insurance program.

lifetime reserve days—a reserve of 60 days of inpatient hospital care available over an individual's lifetime that may be used after the maximum 90 days allowed in a single benefit period has been exhausted.

medical insurance—the part of Medicare which helps pay for medically necessary doctor's services, outpatient hospital services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare as well as some home health services.

medigap policy—private health insurance designed to supplement Medicare.

outpatient facility—a facility designed to provide health and medical services to individuals who are not inpatients.

participating physician or supplier—a physician or supplier who agrees to accept assignment on all Medicare claims.

peer review organizations (PROs)—groups of practicing doctors and other health care professionals under contract to the Federal government to review the care provided to Medicare patients.

prepayment health plans—health care providers such as Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs).

prevailing charge—based upon the customary charges for covered medical insurance services or items, the prevailing charge is the maximum charge Medicare can approve for any item or service.

prospective payment system—a process started in 1983 under which hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay.

reasonable charges—amounts approved by the Medicare carrier which will be either the customary charge, the prevailing charge, or the actual charge, whichever is the lowest.

skilled nursing facility—a specially qualified facility which has the staff and equipment to provide nursing care or rehabilitation services and other related health services.

supplemental health insurance—also called "Medigap" insurance—private health insurance designed to fill some of the gaps in Medicare.

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
6325 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21207

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